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ABSTRACT

Fourteen wilderness and adventure therapy programs in England, Scotland, the United States, and New Zealand were studied to explore critical issues of practice. In view of differences in terminology among countries, various terms and assumptions are defined at length: adventure therapy; wilderness therapy; wilderness-adventure therapy; the continuum of adventure-based practice in terms of "depth" (encompassing recreation, enrichment, and therapy); and unimodal therapy versus multimodal therapy versus adjunctive enrichment. Most programs investigated were multimodal, typically combining wilderness and adventure therapy with parent or family therapy or other group therapies. Unimodal programs tended to be longer-term camping programs. Across countries, different historical, cultural, and social influences have lead to different values and attitudes among adolescent clients, particularly in relation to therapist authority and client autonomy, individualism, and group affiliation. These differences have significantly influenced therapeutic approaches and therapist expectations. Key findings and conclusions relate to trends in the development of the adventure therapy field, the relative importance of program design versus practitioner competencies, client factors associated with better outcomes, holism versus reductionism in therapeutic approach, client rights and ethical issues, consumer perspectives, and gender and power issues. Key elements for best practice are outlined. (Contains 19 references. Appendix outlines program characteristics.) (SV)

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International Models of Best Practice in Wilderness and Adventure Therapy

By Simon Crisp, MPsych, MAPsS

Introduction

This paper is the result of a three month Churchill Fellowship study of wilderness and adventure therapy programs in the UK, USA and New Zealand. The aim of the study was to study 14 different programs (Table 1) and meet with leading authors, trainers, researchers and practitioners in the field. From this study tour, this author has attempted to explore critical issues of practice and develop key elements of best practice in wilderness and adventure therapy. While not a totally comprehensive survey, the programs investigated were intended to provide a representative range of different approaches and models. In undertaking this study, it became necessary to define key terms, program types and comment on socio-cultural influences. Detailed descriptions of each program and deeper discussion of theoretical and definitional issues are expanded in a full report available from the author (Crisp, 1997).

Background

An investigation of innovative methods using wilderness and adventure interventions in mental health programs is particularly important at this time. There is a need for more effective and more accessible means for not only treating, but also providing protection against severe mental health problems, particularly in adolescence. As the field grows, directions in program development and methods of practice need to be described and delineated so practitioners and administrators can ensure standards are maintained and strive to be the best possible. The successful maturation of an emerging field needs to be able to show the efficacy and full potential of the intervention in order to be maximally accepted. Indeed, adverse outcomes and malpractice may represent the greatest threat to support and acceptance of this approach, which is critical to its future development.

What is needed is a treatment approach which gives people the chance to address the core of their mental health issues in a way that minimises stigma, but also promotes development in crucial areas of competency and performance, responsibility, judgement, social orientation, motivation and identity. Benefit would also be provided by enhanced

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resilience to stressors and precipitants of mental health problems therefore adding protection against future difficulties. Evidence already points to wilderness and adventure therapy as being able to provide this (Davis-Berman & Berman, 1994; Gass, 1993; Gillis & Babb, 1992). Many innovative and varied programs have existed and been developed in other countries for many years, even decades. None more so than the United States (Davis-Berman & Berman, 1994), and to a lesser extent New Zealand and Great Britain.

Table 1
Programs Investigated (chronological order)

Program Name	Location
Basecamp	Dumfries, Scotland UK
Brathay Hall Youth Program	Cumbria, England UK
Eagleville Hospital Challenge Program	Eagleville, Philadelphia USA
Lifespan Wilderness Therapy Program	Dayton, Ohio USA
The Browne Centre, University of New Hampshire	Durham, NH USA
Talisman School - Camp Elliott	Black Mtn, N. Carolina USA
Project Adventure - LEGACY Program	Covington, Georgia USA
Inner Harbour Hospital	Douglasville, Georgia USA
Three Springs	Huntsville, Alabama USA
Colorado Outward Bound School	Denver, Colorado USA
Santa Fe Mountain Centre	Santa Fe, New Mexico USA
Anasazi Foundation	Mesa, Arizona USA
Aspen Youth Alternatives	Loa, Utah USA
Special Education Service - Otago	Portobelo, Dunedin NZ

While undertaking this study, it quickly became apparent that culture, history and tradition had a significant influence on methods of practice. In particular, how culture relates to group norms, authority of the therapist, group affiliation, meaning and connotations of language, identity, and so on. In addition, notions of 'mental health' and the sociological influence on problems effect how programs are developed and how they relate to other services. Together with historical precursors, this has contributed to the diversity of program types and how they are applied.

The objectives of this paper are, a) to compare programs in key areas (see Appendix), b) to clarify any theoretical issues which may be relevant to best practice, and finally c) to discuss and draw conclusions about practice and professional issues from the programs investigated and discussions with leaders in the field.

Scope of the Study and Reliability of Data

The data for the study is derived from a combination of structured and unstructured interviews, program literature (where available), direct observation and participation in activities with client groups, and observation and participation in training programs. While the report is primarily based on the programs listed in Table 1, many of the published leaders in the field were also interviewed including Lee Gillis PhD, Dene Berman PhD and Jennifer Davis-Berman PhD, and Michael Gass PhD. Training

programs were also visited including the Masters of Science degree in Psychology (Adventure Therapy track) at Georgia College, Milledgeville, the Wilderness Counselling Stewardship course run by Lifespan Wilderness Therapy Program, and under-graduate and graduate programs in Outdoor Education at the University of New Hampshire at Durham.

Definitions and Assumptions

Travelling between countries, it quickly became apparent that professionals used terms differently. Additionally, much of the empirical research is poor at providing operational definitions, which would allow reliable replication. The definitions arrived at in this paper are the result of discussions with numerous professionals and through observations of practice within programs. These terms and distinctions are the simplest and most useful I could develop. While some authors may argue about the following definitions, there is a need to be clear about the meanings of key terms I shall be using.

Adventure therapy.

Adventure therapy as a term is frequently used to include, more-or-less, the entire field of wilderness, outdoor and adventure interventions. Other times it refers to specifically short-term, non-wilderness based non-residential approaches such as ropes course and initiative activities. This becomes confusing, and tends to hide important differences in practice and assumptions about therapy.

Here, I define adventure therapy as a therapeutic intervention, which uses contrived activities of an experiential, risk taking and challenging nature in the treatment of an individual or group. This is done indoors or within an urban environment (i.e., not isolated from other man-made resources), and does not involve *living* in an environment (e.g., participants do not cook their own meals or sleep overnight). The emphasis is on the selection and design of the activity to match targeted therapeutic issues and the framing and processing of the activity (Gass, 1995). Examples of such contrived activities include group trust, initiative and problem solving activities (Rohnke, 1984 & 1991; Rohnke & Butler, 1995), ropes and challenge elements (low and high), indoor climbing gyms, and so on. I would distinguish adventure therapy by its emphasis on the contrived nature of the task, the artificiality of the environment and the structure and parameters of the activity being determined by the therapist, such as setting of rules, goals and criteria for success or failure. Specific outcomes are usually planned and sought for through careful framing prior to the activity. In practice, adventure therapy typically utilises metaphoric, strategic and solution oriented paradigms (for specific applications see Gass, 1993), and often addressed specified behaviours such as impulsiveness, assertiveness, substance abuse relapse, etc. Theory of change tends to be based around the systemic concept of 'disequilibrium' (Nadler & Luckner, 1992).

Wilderness therapy.

Wilderness therapy can be contrasted with adventure therapy through the emphasis given to the impact of an isolated natural environment[1] and the use of a living

[1] An emerging holistic paradigm that emphasises the importance of the wilderness environment and lifestyle in healing is "ecopsychology" (see Roszak, Gomes & Kanner, 1995).

community. Theory of change was often based on concepts of "adaptation." The combination of environment and community can be encapsulated in the notion of a "therapeutic wilderness milieu," and typically include two different intervention formats: 1) *wilderness base camping* - establishing a camp with minimal equipment in an isolated environment, and 2) *expeditioning* - moving from place to place in a self-sufficient manner using different modes such as back-packing, rafting, canoeing, cross-country skiing, etc. Base camping is frequently combined with expeditioning, while expeditioning is often used exclusively. Therapeutic paradigms frequently include generic group therapy and group systems models, and inter-personal behavioural methods. Experiencing of natural consequences of behaviour was also emphasised. Outcomes are frequently related to social roles, patterns in relationships and notions of adaptation (both social and environmental). Change is often (but not always) seen to be holistic, coupled with personal and inter-personal insight, and to emerge from a social process over time. Perhaps overly simplistic, wilderness therapy involves modified group psychotherapy applied and integrated into a wilderness activity setting.

Wilderness-adventure therapy.

Wilderness-adventure therapy can be thought of as distinct from, but related to the previous two types. Here wilderness activities may be done in a short session format, or where a natural (but not necessarily isolated) environment is used for an adventure therapy type of activity. Examples include rockclimbing or abseiling on natural rock or a caving activity conducted in a real cave, over several hours or within a day. The activity does not extend over night (so there is minimal emphasis on community living), but the activities utilise qualities of the natural environment. For research purposes wilderness-adventure therapy in particular should be differentiated from wilderness therapy and from adventure therapy.

Wilderness and adventure therapy versus enrichment versus recreation.

Based on the surveyed aims and program descriptions of a number of adventure therapy programs for families (mostly ropes course based) Gillis, Gass, Bandoroff, et al. (1991) placed these along an uni-dimensional continuum representing "...the depth of intervention used..." (cited in Gass, 1993, p74). This is represented by Figure 1 (adapted from Gass, 1993).

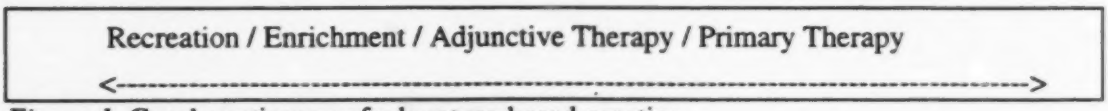

Figure 1. Gass' continuum of adventure-based practice

The level of "depth" is determined according to the following surveyed factors; specific needs of the client and the complexity of therapeutic issues, background training and therapeutic expertise of the therapist, length of time, context of the client, presence or absence of follow-up, availability of adventure experiences, and therapist's

ability/limitations in using adventure experiences in his/her treatment approach (Gass, 1993).

However, rather than a graduated continuum, it would seem even more useful to highlight distinctions based primarily on the *presence or absence of therapeutic procedures*, such as an assessment and diagnostic formulation, specificity of treatment objectives that relate to causative processes, and the use of an individual treatment plan (Figure 2.). Length of time, context of the client, complexity of client's therapeutic issues, availability of adventure experiences and the therapist's ability/limitations in using adventure experiences in his/her treatment approach, although related are functionally *independent* of whether a therapeutic approach is being utilised (according to the definition I use here).

Recreation	Enrichment	Therapy

Figure 2. Simplified delineation of adventure-based practice continuum

My definition of therapy involves the treatment of an underlying dysfunction which seeks a specific change following a diagnostic analysis of a long-standing problem or behavioural pattern (for further discussion see Crisp, 1996; Davis-Berman & Berman, 1994). Enrichment is the provision of a positive and potentially beneficial experience, which can enhance the client's position relative to their disorder or dysfunction but does not attempt to directly address the underlying cause of a client's problem. Any therapeutic change, which may occur, is likely to be accidental (i.e., unpredictable and unplanned, and may be transitory in nature). Change is likely to be transitory because the underlying process, which maintained the dysfunction, would probably still remain. Indeed, many practitioners report concerns regarding the short-lived nature of some therapeutic changes they had seen clients make because underlying contributing and maintaining factors such as family issues or peer influences were not addressed. Enrichment interventions typically aim to give the client a positive experience, which is intended to be of benefit. There is no, or at most only a cursory attempt to understand the causal or maintaining processes underlying the client's dysfunction. Indeed, interventions are commonly made on the assumption that the experience in itself will move the client towards psychological health. That is, individualised outcomes for the client are not specified nor deliberately worked towards.

Here we can see that although enrichment may not directly deal with the process underlying dysfunction, it is still valuable as the experience may indirectly move the client to a more advantageous position relative to their problem. Alternatively it may strengthen a client's resources or coping mechanisms against the factors causing dysfunction following treatment. An example would be to increase self-esteem for substance abusers rather than deal with the causes of substance abuse itself, such as depression or isolation or sexual abuse, and so on. However, as the process underlying the dysfunction is likely to be unchanged, enrichment does not constitute treatment of the disorder, and is therefore importantly different from therapy.

Récreation lies in contrast to both therapy and enrichment, particularly in the assumption of adequate functioning and psychological health. Here, the individual will extend their normal functioning to greater levels of achievement based on a spontaneous learning process, which is determined by the interaction of the individual with experience.

Clearly the aim is not to set out to address an individual's problem but to enhance achievement processes. Again, where an individual may be able to increase achievement this is likely to be of benefit but clearly does not involve treatment of dysfunction, and therefore is not therapy.

In practice, the presence or absence of a number of important elements typically draws the above conceptual distinctions. Not least is an implied or explicit contract between client and service provider. This contract includes the intended aim, and therefore outcomes of the intervention, the role the client will take, including the degree and type of disclosure made, and what the role of the person providing the intervention will take with the client, that is, as therapist, facilitator or educator. The steps of making some form of diagnostic assessment and deriving a treatment plan based on the specific individual circumstances of the client are crucial elements of a therapeutic process. Further, drawing on a knowledge base and theory about the type of dysfunction or disorder during assessment will guide a therapeutic approach. On the other hand, enrichment and recreation typically takes a universal or standard approach to all clients that relate little to a theory of therapy or psychological disorder.

An analogy may be useful to illustrate these points. In a physically normal person, exercise such as running may be highly beneficial to increase fitness and improve quality of life. However, for someone with a broken leg in need of treatment, what is "therapeutic" is a treatment intervention which takes account of the nature of the dysfunction (i.e., diagnosis of the type and site of the break) along with a treatment plan that is based on a knowledge of the healing process (i.e., a re-aligning the bones into the correct position, immobilisation, followed by graduated specific exercises which are reviewed and modified), and so on. While gentle, cautious walking may be an adjunct to the treatment process at the appropriate time (like enrichment), and running becomes beneficial once the limb is functional (like recreation), neither of the latter two are sufficient as a treatment or therapy for a broken leg.

Further, a healthy person doesn't visit a hospital physiotherapist if they want to enhance their fitness and sporting ability, neither does a person with a broken leg consult a fitness trainer for treatment of their broken leg. While both professionals share a common knowledge base of anatomy, physiology, biomechanics, etc. the physiotherapist has specialist skills in diagnosis and treatment and works within a system which can provide adjunctive treatment if needed (e.g., x-ray assessments, anti-inflammatory medication, etc.). Clearly, the client may consult both of these professionals at different times for different purposes. The client has very different expectations about what is being offered and how, and what outcome is being sought. The specifics of the contract, role and relationship between client and professional will be obviously different depending on whether the client consults the fitness trainer or the physiotherapist.

Uni-modal therapy versus multi-modal therapy versus adjunctive enrichment

While enrichment has been differentiated from therapy in the previous section, there are clear differences in the *mode* of wilderness and adventure therapy which hold important distinctions from what can be termed "adjunctive enrichment" (Figure 3.).

Recreation	Enrichment	Uni-modal Therapy
	Adjunctive Enrichment	Multi-modal Therapy

Figure 3. Schematic representation of enhanced levels of programming in adventure-based practice.

Uni-modal Therapy is where wilderness or adventure therapy is the only therapeutic intervention used to treat a problem. There may be supporting activities surrounding this including such things as an assessment process, case management and follow-up, but the primary therapeutic intervention is the wilderness or adventure therapy. Group size may vary but tends to be similar to other group therapies (i.e., 6-8). An example of this includes the Lifespan Wilderness Therapy Program. These types of interventions are typically carried out by highly qualified clinicians with a broad range of therapeutic skills. This should be contrasted and compared with Gillis, et al.'s (1991) description of "primary therapy."

Multi-modal Therapy is where wilderness or adventure therapy is combined with other therapies either concurrently or in series. There is frequently a clear clinical rationale used to guide the way the therapies are combined and the different therapies are unified by an overall treatment plan. Common examples include combining adventure therapy with individual therapy or group therapy as part of an overall therapeutic program (concurrent: e.g., Eagleville Hospital), or individual or family therapy prior to, or following a wilderness therapy intervention (e.g., The Browne Centre, Adventure Development Program). The objective of this paradigm is that the different therapies combined will have a complimentary and compounding therapeutic effect.

This is to be differentiated from *adjunctive enrichment.* Gillis, et al's continuum model uses the term "adjunctive therapy" where it is implied that wilderness or adventure therapy as an adjunct to other therapies involves a lesser (therapeutic) "depth"' than "primary therapy". Examples which contradicted this notion were found, such as a number of therapeutic wilderness camping programs. A more useful and accurate distinction can be made between programs, which use wilderness and adventure experiences as an adjunctive *enrichment* to other therapies, and those programs, which use multi-modal wilderness and adventure *therapy* with conventional therapies.

In the former, the wilderness or adventure enrichment does not involve therapeutic practices, and is likely not linked with other therapy by an overall treatment plan while in the latter the therapeutic process of the wilderness or adventure therapy intervention may be just as involved as uni-modal therapy. It seems more accurate and more useful not to use the term "adjunctive therapy," but rather to differentiate between "multi-modal therapy." and "adjunctive enrichment." Similarly, Gillis, et al's notion of a *continuum* of therapeutic depth seems less helpful than discrete delineation. By my definition above, either something is therapy, or it is not.[2] What should differentiate the two is whether therapeutic procedures are instituted (therapy) or not (enrichment).

[2] In the same way someone is either a 'therapist', or they are not. You cannot be 'a little bit' of a therapist, and someone else 'very much a therapist'.

Typology of Different Programs[3]

Uni-modal programs.

Of those investigated, uni-modal programs tended to be longer-term approaches such as wilderness therapy and therapeutic wilderness camping programs. While no other forms of therapy were undertaken, some screening and assessment sessions were often included prior to the therapy intervention, and/or parent contact was maintained for the purposes of discharge planning and other case management needs. A good example of this type is the Lifespan Wilderness Therapy Program (which also functions, as multi-modal depending on client need) and Aspen Youth Alternatives.

Multi-modal programs.

These programs were the majority of those investigated, and spanned a range of settings from clinical in-patient (e.g., Eagleville Hospital), comprehensive mental health facilities (e.g., Inner Harbour Hospital), experimental out-patient programs (e.g., The Browne Centre), therapeutic wilderness camping programs (eg., Three Springs), and wilderness and adventure therapy (e.g., Colorado Outward Bound School Survivors Of Violence Program, and the Adventure Development Program).

Most commonly, the wilderness or adventure therapy was combined and integrated with parent and/or family therapy either concurrently or in series. This indicates recognition of the need to address broader systemic issues, which is consistent with conventional clinical practice. In larger, highly structured programs, other group therapies such as drama and art therapy, equestrian therapy, horticulture therapy, etc. were combined with wilderness and adventure therapy. Less common was the routine combination of individual therapy with wilderness and adventure therapy. This may be indicative that most programs tended to emphasise the working of individual issues through the group, or that any unresolved individual issues are addressed prior to the wilderness or adventure therapy intervention.

Cultural & Social Influences

It quickly became apparent that broader systemic and social factors have influenced the establishment and growth of wilderness and adventure therapy in the three countries visited. These variations were also apparent regionally, particularly within the USA. For that reason the following tentative hypotheses and observations are included for consideration. An excellent historical account of the development of wilderness therapy programs in the USA is given in Davis-Berman and Berman (1994).

Historical, cultural and class influences seem to have lead to different values and attitudes amongst clients, particularly in relation to authority of the therapist and the importance of autonomy, individualism and group affiliation of clients. These differences have significant influences over therapeutic approaches and expectations of the therapist when conducting wilderness or adventure therapy. While class issues appear to be

[3] A good discussion of the variety of therapeutic and enrichment programs in the USA is given in Davis- Berman & Berman (1994, p 61-84).

significant in how clients are worked with in the UK, things like street gang culture, attitudes to authority and group affiliation tend to shape methods for USA clients.

Certainly, there seem to be significant differences between Australian adolescent group behaviour and that of other countries. For example, while Australians tend to value independence and coping by oneself, Americans appeared to place a high value on gaining support and acceptance from the group. While standards of behaviour such as the demonstration of respect, honesty and supportive confrontation and feedback were relatively unquestioned by USA clients, this is less so in Australia. Here, anti-authoritarian attitudes and conflict avoidant behaviour is more prevalent. Again, while authority of the therapist is a relative 'given' in the UK and USA, this is often a source of tension with Australian clients. Group approaches such as Adventure Based Counselling (Schoel, Prouty and Radcliff, 1988) require adaptation to take account of these cultural differences. Indeed, it may be the case that such approaches are not as effective for many Australian clients as they are in the USA where they were developed.

Key Findings & Conclusions

Current status and future directions of the international field.

It can be concluded that much innovation and program development has occurred in the USA in recent decades, and as such the literature is dominated by North American authors. This places the USA to lead the field internationally, which is evidenced through international memberships with the Association for Experiential Education. While countries will, and should develop unique approaches and practices for local conditions, the field in the USA will tend to remain a leading reference point and be a source of information about best practice in the foreseeable future. However, it is important to consider the influences of local issues and how these shape the field locally, and to appreciate the unique context, needs and opportunities in other countries.

It is clear that health and mental health systems in the countries investigated underpin many of the directions the wilderness and adventure therapy field takes. Concerns and debate around issues of practice seem to be often influenced by economic concerns. Staffing and program formats are apparently shaped significantly by funding opportunities and constraints. Indeed, it was not the lack of research that was considered a potential obstacle to the field's development, but funding mechanisms of insurance companies in the USA as wilderness and adventure therapy are relatively cost intensive (Michael Gass, private conversation).

This appears to be a reason why brief, strategic and solution oriented therapies, including system approaches, heavily influence models and theoretical development (as is the case generally in the therapeutic professions in the USA). Psychodynamic and other established theories were seldom discussed as offering much understanding. While the relative benefits of different therapeutic approaches will be a point of debate for some time, local factors in the USA (that may not be so relevant outside the USA) may preclude the development of alternative models, which may serve the field well in other countries.

Concerns and debate over the term "therapy" in the USA appear to accompany fears that how this term is defined may exclude may non-licensed or non-therapeutically trained outdoor educators. I believe it is important to keep separate the concept of therapy to a narrow and strict definition in this context as not doing so casts confusion and

needless debate over semantic, theoretical and practice issues. At this stage, the profession is both enriched but also handicapped by a diverse range of professional and theoretical affiliations each with their own professional agenda and terms of reference. This continues to lead to confusion in language and theoretical assumptions in the literature. While it may take some time to form a universal theoretical and semantic base, authors should endeavour to define their terms whenever entering the debate.

While the bulk of literature comes from the USA, other countries need to maintain and develop local arenas focussed on local needs for developing and debating theoretical and practice issues. There is some risk that one method and theory will dominate. There is a need to clinically evaluate the relevance and efficacy of North American or British approaches and adapt these to local social, cultural, health care and environmental conditions.

Program design versus practitioner competencies.

Program format, structure and activity types undoubtedly shape the experience for the client and create the frame for therapeutic work. However, the skills of the therapist significantly determine the specificity of psychological and behavioural changes necessary for treatment of underlying dysfunction (Gillis, 1995; Davis-Berman & Berman, 1994). Often these processes and techniques are complex. Frequently with adventure therapy programs, a detailed assessment of the individual or family is used to determine activity selection and metaphoric framing of activities, while elaborate debriefing and 'processing' following the activity seeks quite specific outcomes. Additionally, in wilderness therapy programs therapists typically bring high levels of skill in case analysis and a range of different therapy approaches. Also, wilderness therapists need to be able to manage aggressive behaviour, to respond to crises and manage psychiatric emergencies in isolation from other assistance. For an excellent discussion on this and related issues see Berman (1996).

With regard to adventure therapy teams, most practitioners I discussed this with conceded the expediency of combining two people with requisite skills and would acknowledge that to have therapists "cross-trained" (to be fully competent in both safety and technical as well as therapeutic areas) was preferable. Simply adding these skills together is not enough to ensure good practice, and how the skills would work together in a complimentary way is perceived as particularly problematic (Colin Goldthorpe, private conversation). The arguments against cross training were consistently based on economic and practical considerations, which were of most concern in the USA.

From a program perspective, practitioner roles allow a rough dichotomy to be drawn. On one hand, larger scale programs employed many staff within a hierarchical supervision structure. Here, instructional staff under supervision of qualified and licensed counsellors undertook the bulk of direct care. They typically took the role of administering a well developed, universal behaviour modification program - most commonly based around a level system, which accorded privileges upon achievement of desired behaviour over time. Progress was reviewed routinely and any other issues were addressed through case planning meetings. Additional intervention strategies would usually be implemented by the instructional staff under supervision within the structure of this universal behavioural program.

On the other hand, other programs, which were usually shorter and smaller, had fewer staff but they were usually qualified mental health professionals with additional

wilderness and adventure training. The wilderness or adventure medium was used for the application of sophisticated therapeutic approaches such as systemic, strategic, narrative interventions as well as group psychotherapy. Here, complex assessment of the client (and/or family) was inter-linked with therapy and interventions were highly individualised. Typically, client change appeared more rapid and the therapeutic approach was reviewed and modified more frequently (i.e., daily).

This dichotomy could be summarised in that longer-term, larger programs emphasised generic program structures to achieve broad based universal changes, while shorter-term programs emphasised therapist analysis and eclectic, selective intervention to achieve individualised outcomes. Evaluative research will determine if more therapeutically qualified staff and flexibility of intervention approach achieve a greater efficiency as suggested by this dichotomy.

Client types, diagnostic issues & differential outcomes.

Practitioners reported some variation in client outcome between wilderness and adventure therapy. Client factors reported to be associated with *better outcomes* included:

the client having a physical orientation,
the client having a capacity for reflection,
the client having some environmental awareness,
the composition of the group,
families with the ability to think metaphorically (in family adventure therapy),
the recency of trauma or mental health problem,
internalising disordered clients,
the client having family support,
the client having a greater understanding of group processes,
the client having some educational success.

Poorer outcomes were thought to occur for males with long established behavioural patterns, clients with IQ less than 80, clients with sociopathic traits, Attention Deficit Disorder with hyperactivity, Conduct Disorder and family dysfunction. Substance abusers were felt to be more difficult to motivate. Conduct Disorder seems to have both good and poorer outcome. This possibly indicates some other factor, which mitigates their response to therapy. Those clients thought to respond well included, voluntary clients (compared with involuntary clients), older and female adolescents, suicidal and depressed clients, and clients with low motivation and low self-esteem. Oppositional-defiant Disorder & Conduct Disorder (if spread amongst other clients in a group), Borderline Personality Disorder and younger males were thought to respond better here than to conventional therapies, but all require longer treatment.

To answer the question of "which therapy for which type of client" is an important one, but at this time can only be answered using anecdotal evidence. While further empirical research is the only way to answer this equivocally, the above practitioner reports would suggest outcomes for different clients are similar for other therapies. Therefore the unique therapeutic value of wilderness and adventure therapy may lie in its particular suitability for physically oriented, non-verbal, behaviour or personality disordered, younger male clients who are poorly motivated. This profile fits with those

who don't respond well (or quickly) to conventional therapies and whom in the author's own experiences do respond better with wilderness and adventure therapy.

Holism versus reductionism.

Paradigms that are central to wilderness and adventure therapy are holism on one hand, and reductionism on the other. Balanced co-existence of these two seemingly contradictory paradigms is an essential issue in best practice. The paradigm of holistic understanding extends beyond the individual to incorporate a systems and broader systems framework such as the influence of family, community and culture. None-the-less, at the individual level, a unique feature of wilderness and adventure therapy is its multi-sensorial learning modality. The intensity of environmental and physical demands engages all sensory systems in a learning and change process. This is particularly important for clients who may be less able to utilise verbally based therapeutic approaches, as was frequently mentioned by practitioners.

In addition to this is the multi-functional nature of activities. That is, wilderness and adventure activities simultaneously develop a diverse range of skills. This includes personal organisation and living skills such as cooking and hygiene, physical fitness and self-care, judgment about risk-taking, regulation of affect such as anxiety and anger, inter-personal skills including communication of concepts and ideas, expression of emotion, conflict negotiation, empathy and insight into social processes, and cognitive development such as thinking styles and logical reasoning. Both the scope for clinical assessment of a client's bio-psycho-social capacities as well as intervention in all of these areas is considerably more than most conventional therapeutic approaches. It is the broad spectrum of client functions involved that makes wilderness and adventure therapy especially holistic.

Psychological research on information processing and memory strongly suggests that such integration of experience for the client is more deeply anchored because of this broad base. It is the multi-sensorial and multi-functional nature of therapy that may well account for the pervasive and accelerated rate of change reported by practitioners. For this reason, practitioners need to be able to think holistically level about client needs and intervention options. In doing their work, therapists need to have firm theoretical foundations in body systems, psychological processes such as the relationship between cognition and emotion, sensory processing, as well as systemic principles of small groups, family issues and broader systems such as community and social institutions. Indeed, the capacity to analyse complex individual and group phenomena was seen to be an essential skill in the therapist (Colin Goldthorpe, private conversation).

On the other hand, in order to guide and focus a therapeutic approach, practitioners need also to be able to take a reductionistic perspective when considering treatment needs and priorities. That is, to be able to identify what problem or disorder the client is presenting for treatment and how this will manifest in an adventure activity and wilderness setting, what the nature of this disorder's etiology for this particular person is (assessment and diagnostic formulation), and what steps the client needs to take to move towards greater mental health (treatment planning). Davis-Berman & Berman (1994) and Crisp (1996) discuss this point further.

Client rights & ethical issues.

It is both surprising and concerning that client rights and ethical issues don't take a greater place in the literature and discussion within the field. Issues around the development of new techniques, program models and industrial issues seemed to dominate much of the discussion about the future of the profession. Exceptions to this are the emphasis on therapist qualifications given by Gillis (1995) and Davis-Berman and Berman (1994), and a code of ethical practice produced by the Therapeutic Adventure Professionals Group of the AEE. (Gass, 1993). Despite many publications on theoretical and technical topics, papers on ethical issues pertinent to wilderness and adventure therapy are few and tend to be brief in their coverage (Mitten, 1994; Davis-Berman & Berman, 1993).

However, Hunt (1986) provides a good discussion of ethical issues related to outdoor education generally including risk-benefit analysis, informed consent (including known outcomes and side effects), deception, secrecy, captive populations, sexual issues, environmental concerns, and individual versus group benefit. This is a good starting point for extrapolation to therapy relevant issues. However, ethical issues specific to clinical and therapeutic applications need to be explored and discussed in detail.

Unique and important factors, which require consideration, include the following. Significant physical dependence clients have on the therapist, forming and maintaining appropriate and therapeutic boundaries where these are frequently challenged by the nature of activities and multiple roles the therapist assumes, the unique and multi-faceted role of the therapist in a living situation with his/her client (including managing 'transference' in the client and 'counter-transference' in the therapist), the use of activities which have the potential to cause injury, death or psychological trauma as a form of therapy, involuntary treatment, using methods whose psychological processes are thought to be powerful but are not fully understood, and peer group coercion to modify behaviour are just a number of complex ethical issues.

Despite the "full-value contract" for clients to negotiate with the peer group as part of the Adventure Based Counselling approach (Schoel, Prouty & Radcliffe, 1988) there are no comprehensive guidelines for therapists on the rights of clients that sufficiently address issues relating to the needs of clients in isolated wilderness programs or adventure therapy programs. (Editor's note: The Therapeutic Adventure Professional Group of the Association for Experiential Education has had a comprehensive code of ethics since 1991 for all adventure therapy professionals.) While such rights would naturally vary to some degree depending on country, state and mandate of the wilderness or adventure therapy service, every program should have these written and available to clients. Some programs such as Three Springs did endeavour to do this.

Consumer perspectives.

Many programs emphasised a high level of client involvement in activity selection, expedition planning, and choice of venue. This seemed a valuable opportunity for client empowerment where attention was given to developing reality orientation through planning. Much supervision and guidance was given to client decision making with an emphasis on learning about the process and building better reality-testing skills. This is in contrast to simply giving freedom to clients to be self-directed without any support or guidance.

Gender and power issues.

Many practitioners reported concerns that men historically and traditionally dominated the field, and that there was a perception by the general population that wilderness experiences were the domain of males. Additionally, many traditional roles for men were not necessarily positive by current community standards and tended to emphasise control of the environment (in contrast to self-control) and an external, 'acting-out' orientation. On the other hand, traditional roles for females in wilderness and adventure activities were less prominent and tended to be less positive. Cole, Erdman & Rothblum (1995) is a key reference which explores many of these issues as they relate to women.

Many concerns are raised about the differential appeal to both sexes of this form of therapy. It was a consistent finding that females were just as interested in wilderness and adventure approaches as males in mixed sex programs. Indeed, many practitioners commented that the impact for females in these interventions appeared to be *greater* for females than males. This may be due to the greater opportunity to break from traditional roles for females.

As much of therapy involves use of the body, physical touch, peer encouragement, overnight living situations and so on, there exist unique opportunities for problems related to gender issues. Power differences that may exist in traditional roles and cultures require that peer influences be carefully monitored so as to not be exploitative or oppressive. As many clients may have come from oppressive or exploitative relationships (for both male and female clients), there exists a high risk that inter-personal patterns may develop between clients, or between client and therapist that further reinforce their past experience. Mitten (1993) provides a good discussion on many of these issues. For therapists, it seems vital that they have a good clinical understanding of unconscious 'transference' and 'counter-transference' issues and are clear about, and skilled in maintaining appropriate and therapeutic boundaries. Mixed sex therapist teams seem important for ensuring therapist self-monitoring of client-therapist boundaries.

Aside from therapist awareness and monitoring of these inter-personal dynamics (i.e., through supervision or therapy), it is also imperative that clients have access to therapist role models of both sexes. It is especially useful for therapists to model appropriate non-oppressive and non-exploitative relationships with each other and with clients where appropriate resolution of any power issues and conflict were able to be observed by clients. Therapists should be able to confidently and effectively break from traditional roles in the division of tasks, styles of inter-personal relating, and so on.

Principles for Best Practice & Service Design

In addressing critical issues in best practice, Drs. Jennifer Davis-Berman and Dene Berman stress the need for the practise of professionalism at the level of existing mental health professions. This includes the disciplined application of therapeutic procedures based on established therapeutic theory. On a practical level, they call for two key professional resources. First, fully trained wilderness and adventure *leaders* with the technical and safety management skills; and second wilderness and adventure *therapists* who are mental health professionals with experience in the clinical treatment of clients with diagnosable disorders. Qualified therapists should be involved in delivery of therapy

themselves, or may directly supervise lesser trained counsellors in the field. They are clear about the need to increase the level of training and experience of the therapist, the more isolated the clients are from emergency psychiatric services. Further, comment was made on the need to 'cross-train' professionals in both outdoor education and therapy and develop regulatory mechanisms to ensure good practice. Finally, they argued the importance of high quality, empirical research in maintaining the highest standards of practice and refinement of best practice generally throughout the field (Davis-Berman & Berman, 1994). Dr Michael Gass described what he saw as essential elements in family based adventure therapy interventions:

> Join with the family (form a therapeutic alliance)
> Understand the complexity of families
> Understand the systemic elements of the family and integrate this into the adventure therapy activity
> Physical risk management
> Need to be able to use risk to induce change
> De-briefing and processing skills, especially re-framing

Drawing from the authors above and discussion with many other practitioners, and after distilling aspects of the programs investigated, I conclude the following key elements to be significant in ensuring the highest standards of wilderness and adventure therapy in the treatment of mental health problems (based on the definitions given in the introduction).

Key elements in wilderness and adventure therapy best practice.

Systemic Framework: any intervention or program takes account of systemic (family/significant others) and broader systems issues (class, culture, ethnicity) in such a way that these elements are involved as an integrated part of the intervention. When working with individuals, these issues inform the approaches used.
Assessment Processes: a thorough and individualised intake process occurs, including assessment & diagnostic formulation which assists the understanding of the mental health issue in context of medical, psychological, and social influences.
Treatment Planning: a comprehensive and flexible bio-psycho-social treatment plan is used and is reviewed and modified regularly (e.g., daily or weekly).
Flexibility: therapeutic interventions are flexible and tailored to individual need. Individual needs of clients determine the therapeutic approach from the outset and monitoring of client progress informs subsequent interventions.
Integration: all aspects of treatment, including multi-modal therapies and adjunctive therapies such as individual and family therapy are integrated in a reciprocating fashion. That is, assessment information and issues from each therapy type inform the other. Procedures and methods are developed to ensure continuity, such as group processing methods to link therapeutic issues, use of daily progress notes, therapeutic progress and assessment hand-over meetings.

Monitoring of Client Outcomes: client evaluation pre & post therapy and follow-up is routine to ensure that clients have benefited. This includes a third party's perspective (e.g., family/parent).
Theoretical Paradigm: a clear therapeutic rationale and theoretical paradigm about psychological and behavioural change is well articulated. Established therapeutic methods are delivered by qualified staff in keeping with contemporary clinical frameworks. This paradigm is familiar to all staff and forms the basis upon which treatment decisions are made.
Therapist Skills: include the ability to analyse complex individual and group phenomena. Therapists are able to respond effectively to unexpected client needs in remote settings through a broad range of clinical skills & training beyond their expected role in wilderness or adventure therapy. Additionally, given the rapid growth of knowledge in the area, therapists regularly familiarise themselves with the latest developments in theory and methods. Therapists should undertake some form of regular supervision to develop skills and understanding of therapeutic issues.
Risk Management: physical *and* psychological risk management plans and procedures are developed and reviewed regularly. Standards of program accreditation are adhered to (eg. AEE program accreditation scheme). Procedures for management of medical emergencies, critical and traumatic incidents, and psychiatric crises are developed and reviewed regularly. Precaution and planning and therapist's crisis intervention skills increase as the more inaccessible and physically challenging wilderness therapy interventions become.
Ethical Issues: therapists and program administrators have a thorough and practical understanding of ethical issues unique to this type of therapy (this is a regular topic for staff professional development).
Research: the organisation is involved with evaluative academic research. Research findings are relayed to therapy staff to enrich their understanding of theoretical and methodological issues. Practices are reviewed in light of internal and published research.
Training: the organisation has an internal staff training program or offers open enrolment courses, and maintains a culture of learning and skill development.

While the adherence to all of the above elements pose a challenge, these principles should set a benchmark for best practice. Not-with-standing, these elements should be able to be incorporated into a wilderness or adventure therapy program to varying degrees. Indeed, many if not most programs investigated did achieve this (see Appendix).

Conclusion

An investigation of a number of wilderness and adventure therapy programs and practitioners in three countries has enabled key elements of known best practice to be derived. In doing this, pertinent issues and underlying principles of highest standards are discussed. Concurrent use of the paradigms of holism (of client need and of intervention) and reductionism (in diagnostically based treatment planning) are essential therapist skills and programming considerations. The importance of ethical issues and clients' rights must underpin any intervention models and methods used. Further, cultural and social

values, gender and power issues must be taken into account in order to fully address therapeutic needs and maximise client empowerment.

The field of wilderness and adventure therapy is in the process of clarifying methods as it defines what it is. A search for principles of best practice is essential to guide the field in developing and refining itself into a true profession with the broad community respect, acceptance and genuine social benefit this implies. The greatest threats to the potential of the field are adverse outcomes and malpractice. Striving to achieve best practice is the greatest protection against this and will ensure healthy and strong advancement of the field.

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Appendix: Summary of Program Profiles in Key Areas

Length of program/time frame design: Varied from 2-3 days through to 15 months plus (eg. therapeutic wilderness camping). Time frames varied from entirely part-time through to entirely full-time (eg. Therapeutic wilderness camping: 7 days/week, 52 weeks/year)

Other therapy: Varied from none to extensive range of multi-modal group therapies, only few uni-modal programs

Peak number of clients / group sizes: Varied from 8 through to 165, group size typically was 6-8.

Costs per client: Varied from US$120 to US$500 for residential day costs (ie. clinical or wilderness), typically US$120-150.

Staff qualifications: Varied from minimal safety/technical/first-aid through to cross-trained PhD mental health professionals (eg Psychologists, Social Workers, etc.)

Activities undertaken: Indoor trust and initiative activities, ropes course, back-packing, mountaineering, peak ascent, canyon decent, hand-cart pushing, rock climbing & abseiling, canoeing, kayaking, white-water rafting, cycle touring, caving, survival training, hut building, solo.

Restrictions to access: Typically acute psychiatric & suicidal, self-harming, eating disorders, sociopathic traits, history of extreme violence/substance abuse, IQ<85.

Diagnostic types

Adventure therapy: Varied from: substance abuse, depression, 'youth-at-risk', sex-offenders, ADHD, Conduct Disorder & Oppositional-defiant Disorder, sociopathy.

Wilderness therapy: Varied from all &/or any diagnosis, depressed, suicidal, Oppositional- defiant Disorder, Conduct Disorder, eating disorders, substance abuse, ADHD, sex offenders, substance abuse, family dysfunction, sexual/physical abuse, learning disorders, impulse problems.

Therapeutic wilderness camping: Varied from learning disorders, social skill deficits, Conduct Disorder, Oppositional-defiant disorder, Post Traumatic Stress Disorder, sexual/physical abuse, ADHD, substance abuse, runaways, anxiety, depression and treatment resistant clients.

Outcome differentials.

Adventure therapy: Varied from: universal benefit to just low achievers, environmentally aware and reflective clients, group composition, unified view of the problem in the family, home support. IQ<80 makes processing more difficult.

Wilderness therapy: Varied from: physically oriented otherwise same as for any other type of therapy, older and female respond quicker, short-term substance abusers, older

males, depressed and suicidal. ADHD, Conduct Disorder and family dysfunction are harder to treat.

Therapeutic wilderness camping: Varied from: younger make better progress, recency of trauma, internalising problems, borderline personality disorder, Conduct Disorder & Oppositional-defiant Disorder, low self-esteem. Substance abuse is difficult to motivate.

Individual versus group approaches: Universally an emphasis on the group as the preferred therapeutic medium, some programs gave virtually no individual consideration, while most gave variable amounts.

Involvement of families/parents: Varied from none to primarily outpatient and adventure family therapy. Typically parent support during or on completion of program.

Adjunctive therapies: Varied from none to ad hoc individual therapy, monthly family therapy, pre and post program individual and family therapy. Often agencies were left to institute whatever adjunctive therapy was considered necessary.

Therapeutic models Included: Adventure Based Counselling, eclectic approaches, systemic, narrative, brief, strategic and solution oriented approaches, humanistic, social learning models, therapist as role-model, Reality Therapy, behavioural and cognitive-behavioural, metaphor development, eco-psychology.

Presumed therapeutic factors: Included: holism, systemic, peer culture, rites of passage, success experiences and solution orientation, adaptation, novel context, wilderness environment, competency, risk, questioning, community and group cohesion, natural consequences, inter-personal learning, creation of disequilibrium, goal setting, re-capitulation of family unit, role-modelling, development of resilience, supportive relationships with adults, shared unique experience.

Methods of transfer and follow-up: Varied from none to follow-up days and booster groups, weekly phone calls for months following, home/school trials, parent skill development, ongoing out-patient individual and family therapy, optional return to program for 1-2 weeks, community development activity, transitional housing program, hand-over to agency.

Staffing ratios: Varied from 1:1 to 1:12, typically 1:3 (families, 1:4 families).